Exhibit BB

Jay T. Segarra, M.D., FACP *NIOSH Certified B-Reader*

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Phone/Fax (228) 872-2411

DATE OF RADIOGRAPH: MONTH 11 DAY 09 YEAR 2004

Netter, John E.

WORKER'S Social Security Number: [redacted]

RADIOGRAPHIC INTERPRETATION TYPE OF READING: A [ ] B [X] P [ ]

FACILITY IDENTIFICATION: BCA

Note: Please record your interpretation of a single film by placing an "x" in the appropriate boxes on this form.

1. FILM QUALITY (If not Grade 1, mark all boxes that apply)
1 [ ] [X] 3 R/R
Overexposed (dark) [ ] Underexposed (light) [ ] Artifacts [ ]
Improper position [X] Poor contrast [ ] Poor processing [ ]
Underinflation [ ] Motion [ ] Other (please specify) [ ]

2A. ANY PARENCHYMAL ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS? YES [X] Complete Sections 2B and 2C NO [ ] Proceed to Section 3A

2B. SMALL OPACITIES

a. SHAPE SIZE PRIMARY	a. SHAPE SIZE SECONDARY	b ZONES	R	L
[X] s	p s	UPPER	[X]	[X]
q t	[X] t	MIDDLE	[X]	[X]
r u	r u	LOWER	[X]	[X]

c PROFUSION

0/-	0/0	0/1
[X]	1/1	1/2
2/1	2/2	2/3
3/2	3/3	3/+

2C. LARGE OPACITIES SIZE [X] A [ ] B [ ] C [ ] Proceed to Section 3A

3A. ANY PLEURAL ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS? YES [ ] Complete Sections 3B and 3C NO [X] Proceed to Section 4A

3B. PLEURAL PLAQUES (mark site, calcification, extent, and width)

Chest wall Site	Calcification	Extent (chest wall, combined for in profile and face on) Up to 1/4 of lateral chest wall = 1; 1/4 to 1/2 of lateral chest wall = 2; > 1/2 of lateral chest wall = 3	Width (in profile only) (3 mm minimum width required) 3 to 5 mm = a; 5 to 10 mm = b; > 10 mm = c
In profile O R L	O R L	O R / O L	O R / O L
Face on O R L	O R L	1 2 3 / 1 2 3	a b c / a b c
Diaphragm O R L	O R L		
Other site(s) O R L	O R L		

3C. COSTOPHRENIC ANGLE OBLITERATION R [ ] L [ ] Proceed to Section 3D NO [X] Proceed to Section 4A

3D. DIFFUSE PLEURAL THICKENING (mark site, calcification, extent, and width)

Site Chest wall	Calcification	Extent (chest wall, combined for in profile and face on) Up to 1/4 of lateral wall chest = 1; 1/4 to 1/4 of lateral chest wall = 2; > 1/2 of lateral chest wall = 3	Width (in profile only) (3 mm minimum width required) 3 to 5 mm = a; 5 to 10 mm = b; > 10 mm = c
In profile O R L	O R L	O R / O L	O R / O L
Face on O R L	O R L	1 2 3 / 1 2 3	a b c / a b c

4A. ANY OTHER ABNORMALITIES? YES [ ] Complete Sections 4B, 4C, 4D, 4E NO [X] Proceed to Section 5

4B. OTHER SYMBOLS (OBLIGATORY)

ax at ax ba cn cg cn co cy cv ch cf em es fr hi ho id ih id mc pa pb pi px rn rp sb

OD If other diseases or significant abnormalities, findings must be recorded on reverse. (Section 4C/4D)

Date Physician or Worker notified? MONTH DAY YEAR

4E. Should worker see personal physician because of findings in section 4? YES [ ] NO [ ]
Proceed to Section 5.

5. FILM READER'S INITIALS JTS

DATE OF READING MONTH 11 DAY 09 YR 04

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OCCUPATIONAL LUNG DISEASE EVALUATION November 9, 2004

Netter, John E [redacted]
Biloxi, MS 39530

BCA/LAU/LH [redacted]
DOB: 07/28/49

HISTORY: This is a 55 year old welder who reports exposure to welding dust, sandblasting dust, and asbestos dust during his work within a shipyard, over a twenty-five year period. He went to school through the twelfth grade. From 1974-1998, he spent twenty-four years working in a shipyard as a welder. He wore a welding hood. He welded inside and outside of ships. He removed old insulation from decks before welding. He worked around sandblasters, "every day," without respiratory protection. He states that the sandblasting dust fell down on his clothes on a daily basis. He used fire blankets when welding and he did some grinding. He did not wear any respiratory protection, other than the welding hood, until the 1990s. Beginning in 1966, he has intermittently worked part-time in construction, as a cement finisher and brickmason in both commercial and residential settings. He lays bricks around the outside of houses and buildings. He mixes some mortar and some cement. He has not used any respiratory protection since he started doing this work in the 1960s. For the past year or so, he has worked as a housekeeper in a hospital.

He has smoked one-half of a package of cigarettes daily for the past thirty-three years, since beginning at age 22 in 1971 (16.5 pack-years). There is a family history of hypertension. His mother lived into her seventies. The patient himself has no significant past medical history and takes no medicine on a regular basis at this time. He is apparently allergic to aspirin. There is no prior history of lung disease, pneumonia, or chest trauma. He has had four surgeries on his right elbow over the past ten years.

On general systems review the patient reports stress-related indigestion and gas pains, "every once in a while." He gets cramps in his legs after walking about a block. He denies orthopnea, chronic cough, hemoptysis, wheezing, and significant dyspnea upon exertion. He believes that his exercise tolerance is normal and as good or better than other men his age. He has no respiratory symptoms at pleasant.

PHYSICAL EXAM: This is a pleasant middle-aged African-American man in no respiratory distress at rest. H: 75"; W: 216#; Pulse: 76 and regular; B/P: 104/76. Head and neck: No adenopathy or jugular venous distention. Chest: Symmetric expansion. No obvious chest wall deformities. Lungs: Normal palpation and percussion. Clear to auscultation anteriorly and posteriorly to the bases. No rales, wheezes, or rhonchi are heard. Heart: Regular rhythm, without murmurs, clicks, rubs, or gallops. Extremities: No clubbing, cyanosis, or edema.

CHEST X-RAY: PA and lateral views of the chest dated November 9, 2004 are reviewed for the presence of and classification of pneumoconiosis according to the ILO (1980) classification. Film quality is grade 2, due to scapular overlay. There is a diffuse nodular interstitial pattern consisting of small, rounded opacities of size and shape P/Q, ILO profusion 1/0 in all six lung zones bilaterally. Examination of the pleural surfaces demonstrates no pleural plaques, pleural thickening, or pleural calcifications. No

CHEST X-RAY: (Cont'd) parenchymal infiltrates, effusions, nodules, or masses are present. The trachea is midline. The heart size is normal. The mediastinal structures are unremarkable. The costophrenic angles are sharp. There are no other significant intrathoracic findings. No previous films are available for comparison at this time. A high resolution chest CT may be useful in increasing the specificity of the interstitial findings for pneumoconiosis, should this test become clinically indicated due to either increasing pulmonary symptoms or declining lung function.

PULMONARY FUNCTION TESTING: Performed in Laurel, MS on November 9, 2004 using Crapo/Hsu predicted values. Forced vital capacity (FVC) is 5.58 liters (l.), or 99% predicted (pred.). FEV1 is 4.42 l. (101% pred.). FEV1/FVC ratio is 79%. FEF 25%-75% is 4.48 l./sec. (114% pred.). SVC is 5.58 l. (99% pred.). TLC is 8.33 l. (104% pred.). DLCO is 58% pred., based on an IVC of 5.47 l. Inspection of the volume-time curves, flow-volume loops and diffusion graphs reveals good performance and reproducibility during those portions of the test. These pulmonary function tests, after race correction, demonstrate a mild reduction in diffusion capacity, in a current smoker, with otherwise normal spirometry and normal lung volumes.

DIAGNOSIS/IMPRESSION: [1258] Pulmonary silicosis (mild chronic simple silicosis), based on the appearance of the chest x-ray and the exposure history. Although this condition is causing a mild diffusion impairment, it is currently asymptomatic. Additional radiographic correlation is suggested, when clinically indicated and available.

PROGNOSIS/RECOMMENDATION: Due to the long latency period between exposure to silica and the onset of clinically significant silica-related disease, the patient is at increased risk for the development of bronchogenic carcinoma, tuberculosis, and certain other conditions, as well as for deterioration in lung function, even in the absence of additional silica dust exposure. Since these conditions may occur many years after exposure has terminated, close clinical follow-up, annual pulmonary re-evaluation, and immediate smoking cessation are strongly recommended.

Jay T. Segarra, M.D.

1. Health Effects of Occupational Exposure to Respirable Crystalline Silica, National Institute for Occupational Safety and Health, Publication No. 2002-129, April 2002
2. Silica and Silica Induced Lung Diseases, Castranova V, Vallyathan V, Wallace W, CRC Press 1996 Boca Raton, FL.
3. Goldsmith D, "Silica Exposure and Pulmonary Cancer" in Epidemiology of Lung Cancer, ed. Sammett J, Marcel M. Decker, 1994.
4. Recommendations For Control Of Occupational Safety and Health Hazards... Foundries, National Institute for Occupational Safety and Health, Division of Standards Development and Technology Transfer, Publication No. 85-116, September 1985

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